STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

INDEPENDENT MEDICAL REVIEW
REQUEST FOR EXTENSION OF SIX-MONTH DEADLINE

DMHC / IMR 120 11/27/00

1. Enrollee Information
(To be considered for an IMR, complete an IMR Application and this form.)

Name: _____ Telephone: _____
Day Evening Fax

Address: _____
Street City State Zip Email

2. Reason Enrollee Did Not Submit a Request for an Independent Medical Review Within Six Months From the Date of the Health Plan's Written Denial:

_____

_____

_____

_____

_____

_____

3. List Health Plan's Denial Letter Date, and Other Pertinent Dates:

_____

_____

4. Signature: _____ **Date:** _____

Complete an IMR application and return with this form to Department of Managed Health Care, HMO Help Center, IMR Unit, 980 Ninth Street, Suite 500, Sacramento, CA 95814. If you have any questions, the Department can be reached at (888) HMO-2219, fax (916) 229-0465, TDD (877) 688-9891, or the Department's web site at www.hmohelp.ca.gov.

(Department of Managed Health Care Use Only)

Reviewed By: _____ Date: _____

Reviewer's Signature: _____

Request Decision: Accept / Reject (Circle one)

Comments: _____

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